**STATE PERSONNEL BOARD, STATE OF COLORADO**
Case No. 98B 163

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**INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE**

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PAULA ESGAR,

Complainant,

vs.

DEPARTMENT OF CORRECTIONS,

Respondent.

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Hearing in this matter was held before Michael S. Gallegos, Administrative Law Judge (AU) on October 29 and 30, 1998 and January 6, 7 and 8, 1999. Complainant appeared and was represented by John Keilbach, Attorney at Law. Respondent was represented by Assistant Attorney General Diane Michaud.

## MATTER APPEALED

Complainant appeals a disciplinary termination of employment. For the reasons set forth below, Respondent's actions are **affirmed.**

## PREHEARING MATTERS

### 1. Exception to physician-patient privilege

By pre-hearing order, dated September 11, 1998, an exception to the statutory physician-patient privilege was fashioned in order to allow review, of the documents considered by the appointing authority in making his decision to terminate Complainant's employment., i.e. to determine whether the appointing authority acted arbitrarily, capriciously or contrary to rule or law. Therefore, the exception was limited to those documents considered by the appointing authority in reaching his decision.

**2. Exhibits**

a. Respondent's Exhibits 1, 2 and 5 were accepted for the limited purpose to show that an act occurred and not as proof of the truth of matter asserted within the document, e.g. to show that a prior Corrective Action was imposed, not to show that the prior act was deserving of a Corrective Action.

b. Respondent's Exhibit 4 and the Incident Reports and other documents attached to and made part of Respondent's Exhibit 4 were accepted into evidence over Complainant's objection as hearsay and as to relevancy. The documents are business document exceptions to the Hearsay Rule (C.R.E. 803 (8)) and the incident or event which they report is the same incident at issue here, therefore they are relevant.

c. Respondent's Exhibits 6 and 7, letters from Complainant's attorney regarding procedural matters, were accepted into evidence over object as to relevancy. The letters, however, were relevant to the issue of whether the appointing authority acted arbitrarily or capriciously, i.e. whether he complied with the requests made within the letters.

d. Respondent's Exhibit 3 and 8 was accepted into evidence without objection from Complainant.

e. Respondent's Exhibits 9 through 15 and 17 through 31 were accepted into evidence by stipulation of the parties. The following table cross references Complainant's Exhibits (marked alphabetically) with Respondent's Exhibits (marked numerically):

| Complainant's | = Respondent's | Complainant's | = Respondent's |
|---|---|---|---|
| X | 9 | U | 20 |
| Y | 10 | R | 23 |
| Z | 11 | Q | 24 |
| AA | 12 | T | 25 |
| BB | 13 | J, K and L | 26 |
| CC | 14 | H | 27 |

f. Respondent's Exhibit 16, a transcript of the R833 meeting held in this matter, was accepted into evidence over objection as to relevancy. The transcript was accepted as relevant to the issue of whether the appointing authority acted arbitrarily or capriciously.

g. Respondent's Exhibits 32 through 35 were accepted into evidence under the special exception to the physician-patient privilege indicated above (Prehearing Matters, paragraph 1.) NOTE: These documents are otherwise privileged and, at hearing, were placed under a protective order. Therefore, Exhibits 32 through 35 have been placed in a

sealed envelope within the case file in this matter, i.e. they are not available for public viewing.

h. Complainant's Exhibit W was accepted into evidence by stipulation of the parties.

i. Complainant's Exhibit II, Department of Corrections Administrative Regulation 95-2, regarding the confidentiality of medical records was not accepted into evidence as not having been properly endorsed.

**3. Witnesses**

a. Respondent called the following witnesses: Paula Esgar, Complainant; Michael R. Lynn, Correctional Officer; Larry E. Yarberry, Correctional Officer; Gary L. Skeeters, Sergeant; Lieutenant Wes Gowdy, Arrowhead (ACC) graveyard shift-commander; Renae Jordan, Department of Corrections (DOC) Nurse I, Arrowhead (ACC) day-shift; Diane Al Abdul Jalil, M.D., who testified as a lay witness and DOC co-worker; Carolyn Schilling, Director of Nursing, DOC and Dr. David Holt, appointing authority in this matter.

b. Complainant testified on her own behalf.

## ISSUES

1. Whether Complainant committed the acts for which she was disciplined;

2. Whether the actions of Complainant warranted termination of employment;

3. Whether Respondent's actions were arbitrary, capricious or contrary to rule or law;

4. Whether either party is entitled to attorneys fees and costs.

## FINDINGS OF FACT

1. Complainant was employed by the Department of Corrections (DOC) as a Registered Nurse (RN), a position which she held for approximately 5 (five) years. Complainant became a registered nurse in 1977 and received a Bachelor's Degree in Nursing in 1989. Since then she has taken a course in critical Cardiac Care. Prior to her employment with DOC Complainant worked in private hospitals in Cardiac/Surgical/Medical Intensive Care, on post-

cardiac surgical and post-surgical floors, in emergency rooms, surgery, obstetrics and intensive care units, as a floor nurse, an on-call surgical nurse and a relief charge nurse on a neurological floor, i.e. she had significant experience in assessment, triage and emergency care/treatment.

2. Complainant's work performance evaluations between June 1996 and March 1998 were consistently "Good" (Respondent's Exhibits 9 -11). Complainant's work performance evaluations between November 1995 and June 1996 were "Commendable"/"exceeds expectations" (Respondent's Exhibits 12 and 13). Complainant's work performance evaluations between July 1994 and November 1995 were "Good" (Respondent's Exhibits 14 and 15).

3. On March *5,* 1998 Complainant received a Corrective Action (Respondent's Exhibit 5). She responded to the Corrective Action in writing but did not grieve or otherwise challenge the Corrective Action. In an effort to comply with the Corrective Action imposed, Complainant enrolled in an "ACLS class"/cardiac life support course. However, she did not complete such course prior to the termination of her employment with DOC.

4. Complainant's employment was terminated by letter dated June *15,* 1998 (Respondent's Exhibit 2) for failure "to comply with standards of efficient service or competence" a/k/a "substandard care" to DOC inmate Gerald Medina (Medina) on May 2, 1998 and for "under-reporting a serious problem", GI (gastro-intestinal) bleeding.

*5.* Complainant worked the graveyard shift, 10:00 p.m. to 6:00 a.m., at Fremont Correctional Facility (FCF) on May 1 - 2, 1998. She was the one medical personnel on duty for the East Canon Complex which includes six correctional facilities: Arrowhead (ACC), Centennial, Fremont (FCF), Four-mile, Pre-release and Skyline.

6. Complainant's duties as the "night nurse" on graveyard shift at FCF included: answering the phone, addressing medical problems at other facilities; picking up, counting and logging "kites"; checking requests for medication against the "med sheet"; counting, washing and sterilizing clinic instruments; restocking the emergency equipment and recharging the defibrillator; checking and sealing the "crash cart"; pulling charts for the next day; processing ASAP medical orders ("charts") for inmates from outside physicians and processing any STAT orders. Processing STAT orders takes priority over ASAP orders and should be done immediately, i.e. STAT orders should not be left for the next shift. The night nurse was "on-call" for inmate medical needs at any of the six facilities within the East Canon Complex. Medical emergencies take priority over any and all other duties.

7. During the graveyard shift on May 1 - 2, 1998, Complainant had STAT orders to address, left over from the previous shift.

8. Standard procedure, at the change of shift for medical personnel in May 1998, was to advise the on-coming medical personnel of any special instructions and/or to "flag" medical issues which may need to be addressed by the on-coming medical personnel. This

practice did not include chronic or on-going inmate medical problems. Long-standing problems might be addressed by a note taped to the ledge by the phone at the FCF clinic.

9. Standard procedure for addressing problems at other facilities was to talk to whoever called, then either refer the inmate's problems to the next day-shift medical personnel at that facility or see the inmate. The nurse on graveyard shift could see the inmate in one of two ways: 1) have the inmate brought to the medical clinic at FCF, or 2) go to the other facility to see the inmate at the clinic there.

10. In the event of a medical emergency or "crisis" situation a night nurse could work overtime to address the emergency or situation, including travel to another facility to see an inmate at the clinic in that facility.

11. On occasion inmates will make a false report of symptoms. However, it is the DOC nursing staff practice and procedure to treat all report as true in order to avoid neglecting a true emergency. Of particular concern are reports from inmates of chest pains, vomiting blood, bloody stools, severe headaches or pain, or sudden vision loss.

12. In the event an inmate needs to be transported, during the graveyard shift, to a local hospital for emergency medical treatment, it is up to the night nurse to determine whether the inmate will be transported by van or by ambulance.

13. Standard procedure for DOC correctional staff, when an inmate is in need of medical attention during the graveyard shift, is for the correctional officer with the inmate to collect information from the inmate and/or by observation, then call Master Control at the facility in which they are located. Master Control determines whether the situation "is critical" and if so, will call the night nurse.

14. Only in the event of a "life-threatening" medical emergency, e.g. profuse bleeding from a stab wound, may a graveyard shift commander within the East Canon Complex override any non-responsive decision made or neglected by the night nurse.

15. The shift commander for ACC on May 1-2, 1998, Lt. Wes Gowdy *(See* Respondent's Exhibit 4, page 9) had no medical training other than regular CPR (cardio pulmonary resuscitation) and first-aid training. He did not have the authority to transport Medina to FCF to be seen by the night nurse, to call for an ambulance or to provide medical treatment to Medina.

16. For security reasons, an inmate with a medical problem is not authorized to leave his unit, call or report his problem to the night nurse or to any medical personnel, either DOC medical personnel or private medical personnel, i.e. an inmate cannot call outside DOC for medical attention even if it is a medical emergency.

17. DOC correctional officers are not authorized to act in a medical emergency or to offer any medical treatment. Any treatment given during the graveyard shift must be authorized by the only medical personnel on duty, the night nurse located at FCF.

18. A November 1995 memo (Respondent's Exhibits 29 and 30) directing that Skyline, Four-Mile and Pre-Release inmates needing medical attention be transported, during the graveyard shift, to ACC was still in effect at the time of the incidents involved here. However, Complainant regularly chose to see inmates needing medical attention at the facility in which they were housed.

19. Complainant went to see inmates in need of medical attention at ACC on the average of "once-a-week"/one (1) time each week. On the average, she received between 10 (ten) and 20 (twenty) calls per week from ACC.

20. Each inmate's medical file was kept at the medical clinic in the facility in which they were housed, i.e. in order to look at the hard copy of an inmate's medical file, the night nurse would have to go to the facility where the inmate was located.

21. In the event that the East Canon Complex night nurse required assistance by phone or a referral, there was a "nurse supervisor" on-call (by pager) and at least one physician on-call (by pager). On occasion, however, the on-call medical personnel do not answer their pages.

22. Whenever a physician was contacted by on-duty medical personnel, such personnel must log-in the contact. (Exhibit 4, page 3.)

23. A physician's order is required to transport an inmate to a local hospital for medical attention or for any action other than "standing orders" for a specific inmate. In a medical emergency, however, the night nurse also has the authority to call for an ambulance to transport an inmate to a local hospital.

24. Upon reporting for the graveyard shift on May 1 - 2, 1998, Complainant first received a verbal advisement regarding an FCF inmate with "a gaping wound" that could be a problem. She then began sterilizing instruments, restocking and dealing with charts. At approximately 3:15 a.m. she noticed there were STAT orders left from the previous shift and began to process them. For Complainant, STAT orders take "a fair amount of concentration".

*25.* Correctional Officer Michael R. Lynn (Lynn) worked the graveyard shift (10:45 p.m. - 7:15 a.m.), at Arrowhead, assigned to "Charlie Unit" (C Unit/Unit C). Formal counts of the inmates were done at approximately 2:00 a.m. and 5:30 a.m. on May 2, 1998. During an informal count at approximately 3:15 a.m., Lynn noticed that Medina was in a stall in the bathroom. At approximately 4:00 a.m., during another informal count, Lynn noticed that Medina

was still in the bathroom and asked if he was okay. Medina responded that he was just having another bowel movement.

26. At approximately 4:35 a.m. on May 2, 1998, Medina came to Lynn's office and stated that he was dizzy. Lynn told Medina to take a seat and asked him "What's going on?". Lynn took notes regarding Medina's reported symptoms which included: sweating and nervousness, vomiting blood (approximately 3 pints), numerous bowel movements. Lynn called Master Control and the phone was answered by Officer Larry E. Yarberry (Yarberry). Lynn reported the symptoms to Yarberry in two telephone conversations at approximately 4:38 a.m. and 4:40 a.m. Lynn also reported to Yarberry the Medina had been hospitalized approximately two weeks earlier. Other than the information about a recent prior hospitalization, Lynn did not express concern regarding Medina's physical condition, i.e. he did not say to Yarberry that it was an apparent emergency.

27. Lynn kept Medina in his office for approximately twenty (20) minutes waiting to hear back about whether the nurse would see Medina. During the 20 minutes in which Medina was in Lynn's office, Lynn started writing his incident report. (Respondent's Exhibit 4, page 4.)

28. Lynn was the correctional officer who accompanied Medina to the Emergency Room of a local hospital, approximately two weeks earlier, for stitches. At that time Medina was admitted to intensive care. However, Lynn was unaware as to the reason Medina had been admitted to intensive care.

29. Medina was admitted to the intensive care unit of a local hospital for UGI (upper gastro-intestinal) bleeding secondary to portal hypertension and esophageal vericies. He was treated with esophageal band ligation and blood transfusion and scheduled for the same treatment again in "1 -2 weeks" from April *25,* 1998 (Respondent's Exhibit 35). He was released back to ACC on or about April 28, 1998 with no special dietary instructions.

30. Lynn had CPR (cardiopulmonary resuscitation) and first-aid training. He did not have the authority to transport Medina to FCF to be seen by the night nurse, to call for an ambulance or to provide medical treatment to Medina.

31. Officer Yarberry was providing relief for the officer assigned to Master Control at Arrowhead, on May 1 - 2, 1998 when Lynn's call regarding Medina came in.

32. Master Control (a/k/a the control center) is the area of each facility that takes all incoming calls, addresses all "housing issues" including formal inmate counts and controls access to and egress from the facility. Normally a sergeant staffs the control center and reports to a lieutenant based in another office.

33. Yarberry spoke with Lynn twice by phone regarding Medina. The first time Lynn

told Yarberry that Medina was throwing up blood and was very weak. Yarberry told Lynn that he (Yarberry) would call the nurse on-duty/night nurse.

34. Yarberry is an EMT (Emergency Medical Technician) and worked with Complainant prior to the incidents involved in this matter. Yarberry did not have the authority to transport Medina to FCF to be seen by the night nurse, to call for an ambulance or to provide medical treatment to Medina.

35. Prior to May 2, 1998, neither Lynn nor Yarberry were given any special instructions regarding Medina's medical condition.

36~ Yarberry called Complainant from Master Control at ACC regarding inmate Medina. Yarberry advised Complainant that Medina was vomiting blood. There is some question regarding whether Yarberry told Complainant that Medina had "a history of bleeding". Yarberry did not tell Complainant that it was a medical emergency.

37. Complainant asked what color the vomitus was and whether the blood was red or black in color. The officer answered that he did not know and asked if Complainant was familiar with this inmate. Complainant responded that she was not familiar with Medina. Complainant did not ask any questions regarding Medina's medical history, risk factors or medications.

38. Complainant told Yarberry that she had something to do at FCF and states that she instructed Yarberry to find out the color of the vomitus and call her back. Yarberry states that Complainant told him *she* would call back to get the additional information.

39. Complainant had access (at FCF) to the DOC computer which gives a limited medical history of all DOC inmates. The information is accessed by the inmate's DOC number. Complainant did not ask for Medina's DOC number nor did she attempt to access his medical history within the DOC computer at any time during her shift on May 1 - 2, 1998.

40. The night nurse has the ability to call any of the East Canon Complex facilities, regarding inmate medical problems, whenever and as often as she may deem necessary.

41. The color of the blood in vomit or feces indicates fresh (red) or old (black) blood.

42. Yarberry asked Lynn, by telephone, if he had seen blood or seen Medina throwing up and directed Lynn to send Medina back to his cell to lay down. Lynn responded that he had not witnessed Medina throwing up and had seen no blood.

43. Lynn watched Medina return to his cell. Lynn recalls that Medina walked in a slow-normal pace and appeared stable.

44. Yarberry told Sergeant Gary L. Skeeters (Skeeters), who was assigned to ACC Master Control for the graveyard shift on May 1-2, 1998, that he (Yarberry) had called the nurse regarding inmate Medina and that the nurse would be calling back after she spoke to the in-coming day-shift nurse at FCF. Yarberry wrote an incident report regarding Medina and his telephone contact with Lynn and Complainant. (Respondent's Exhibit 4, page *5.)*

*45.* Skeeters believed that Complainant was doing a "face-to-face" (seeing an inmate) at FCF. He spoke with Lynn two or three times, after Yarberry relieved him, regarding inmate counts and may have asked "How's Medina doing?"

46. Lynn saw Medina again during an informal count at approximately 5:15 a.m. There was no blood visible in Medina's cell, in the bathrooms, halls, stairways or on Medina's clothing.

47. At approximately *5:25* a.m. Complainant realized that she had not heard back from ACC regarding Medina, so she called ACC and was told that Medina was still ill (Respondent's Exhibit 4, page 6). She asked for the information, regarding color of the vomitus, again and was told that they were "in the middle of a count" (the formal 5:30 a.m. count), therefore, it would be a few minutes before they could get the information for her.

48. Skeeters recalls discussing with Complainant when the ACC day-shift nurse was scheduled to arrive and telling Complainant that he believed the day-shift nurse would be in at approximately *5:50* a.m. Skeeters had received CPR and first-aid training but did not have the authority to transport Medina to FCF to be seen by the night nurse, to call for an ambulance or to provide medical treatment to Medina. Skeeters wrote an incident report about his conversation with Complainant. (Respondent's Exhibit 4, page 6.)

49. In order for Complainant, or any night nurse, to go to Arrowhead (ACC) to see an inmate, she would have to lock up the Fremont (FCF) medical clinic, walk to Master Control at Fremont to drop off the keys to the clinic, walk through the facility gates up to the parking lot, drive to Arrowhead, park, "buzz in", walk down to the Arrowhead medical clinic, then to Master Control at Arrowhead to get the keys, then back to the clinic and finally have the inmate brought to the clinic. Complainant estimates the process at 25 to 30 minutes one-way. The return trip would be approximately the same amount of time and during that time the night nurse is unavailable for other duties.

*50.* Although Complainant had the authority to do so, she did not consider calling ahead to Arrowhead to be met at the gates or to have Medina brought down to the clinic at ACC or to have him transported to FCF.

51. Complainant was aware that the day-shift nurse at ACC would be in shortly, at 6:00 a.m.. So Complainant asked Skeeters, the officer in Master Control at ACC, to relay the

matter (Medina) to the day-shift nurse at ACC. Skeeters did not object or indicate in any way that Medina might be in a medical-emergency or life-threatening situation.

52. Complainant did not sense, from any of the telephone calls concerning Medina, that there was a medical-emergency or potential life-threatening situation.

53. Prior to May 2, 1998, Complainant was given no special instructions regarding Medina's medical condition.

*54.* Complainant did not review Medina's file at anytime during the graveyard shift of May 1-2, 1998. She did not see Medina during the graveyard shift of May 1-2, 1998 and Complainant did not write a report on the incident.

*55.* Complainant did not ask for nor did any correctional officer volunteer to bring Medina to FCF so Complainant could see him there.

*56.* Prior to leaving FCF at the end of her shift, Complainant did not call the ACC day-shift nurse to discuss Medina.

*57.* Upon the arrival of the ACC day-shift nurse Renae Jordan (Jordan), Skeeters transmitted the information he had about Medina's medical situation to Jordan. Skeeters told Jordan that Medina was "passing blood". Jordan received the telephone call from Skeeters as she was passing out medications to inmates in a regularly scheduled "therapeutic community" (TC) "med line". Jordan called Lynn while finishing the med line.

*58.* Prior to May 2, 1998, neither Skeeters nor Jordan were given any special instructions regarding Medina's medical condition. Nurse Jordan was unaware of any chronic conditions from which Medina may have suffered, that he had recently returned from the hospital or whether any restricted diet had been set for him (Medina).

*59.* At approximately 6:15 a.m. Lynn received a call from nurse Jordan asking for Medina's symptoms. Lynn relayed the same symptoms that he had communicated to Yarberry approximately one (1) hour and 35 minutes earlier. Jordan told Lynn "bring him over" to the clinic, i.e. she wanted to see Medina immediately. Based on the blood loss reported by Lynn, Jordan felt that the situation was "critical". Jordan recognized that a GI bleed is potentially life threatening, i.e. "loss of blood can lead to death."

60. Jordan chose to have Medina brought to the clinic, rather than go see him in Unit C, because she had necessary equipment and supplies at the clinic.

61. When Lynn went to retrieve Medina, he was in the bathroom having another bowel movement. Lynn reported this to Jordan.

62. Two (2) "zone officers" were sent to bring Medina to Jordan at the ACC clinic. By the time they got there, Medina was in a different bathroom. One of the zone officers asked Medina if he needed a wheelchair. Medina refused such assistance and walked out of Charlie Unit unassisted (approximately 100 yards). Medina left the Charlie Unit at ACC at approximately 6:25 a.m.

63. It is approximately 300 feet total from the bathroom in C Unit, where Medina was, to the clinic at ACC. Medina arrived at the ACC clinic at approximately 6:30 a.m.

64. Between 6:30 and 7:00 a.m., May 2, 1998, Jordan did an assessment of Medina's medical condition (Respondent's Exhibit 32) and paged a physician to get orders for Medina's medical care/treatment. Jordan observed that Medina "looked a little shaky" but she did not see any bleeding or blood. She did observe signs of "altered tissue profusion"! oxygenated blood flow to a specific area of tissue. Medina reported to Jordan that he had "one continuous bowel movement all night" and that it "looked like tar".

*65.* A medical assessment is usually performed by observing the person, reviewing the person's medical history and medical records and performing tests.

66. Complainant did not perform a medical assessment of inmate Medina.

67. Inmate Medina walked to the van for transport to a local hospital at approximately 7:00 a.m. on May 2, 1998. He was helped into the van by one of the officers escorting him.

68. Gerald Medina died, after transport to a local hospital, on May 2, 1998. Inmate Medina's death was due to complications of a "GI bleed", i.e. he bled to death.

69. On May 6, 1998 Complainant met informally with Dr. David Holt (Holt), the appointing authority and Dr. Al-Jalil, a medical doctor and Complainant's co-worker *(See* Respondent's Exhibit 18). During the meeting, Complainant stated that she had been aware, through the telephone call from ACC Master Control, that Medina was vomiting blood. During the meeting, Complainant was asked whether an inmate vomiting blood was a serious medical problem. Complainant responded that it depends on the amount of blood. Complainant was also given the opportunity to respond to the incident reports filed by ACC correctional staff. *(See* Respondent's Exhibit 4, page 1.) She questioned why she had not been given all the information contained within the incident reports. Holt determined that Complainant's reporting of the incident did not conform with the incident reports which he found to be credible. Therefore, as a result of the May 6, 1998 meeting, Holt set a Rule 833 meeting for May 18, 1998. (Respondent's Exhibit 1.)

70. Under DOC practice, and as a matter of sound medical care practice, a person vomiting blood should be taken seriously regardless of the amount of blood present in the vomitus.

71. After the May 6, 1998 meeting, Holt met with Officers Lynn, Yarberry and Skeeters, reviewed the incident and their incident reports. Nurse Jordan and the Nursing supervisor, Brad Kinney were also present at that meeting.

72. On May 18, 1998 a Rule 833 meeting was held with the following persons in attendance: Dr. Holt, the appointing authority; Complainant and her attorney; Brad Kinney, the nursing supervisor and Brad Rockwell. As a result of the R833 meeting Complainant's employment was terminated. (Respondent's Exhibit 2.)

73. At one of the meetings Complainant indicated that she could not attend to Medina on May 2, 1998 because the STAT orders needed her attention. At some point, prior to the appointing authority's decision to terminate her employment, Complainant also stated that she could not attend to Medina due to an inmate at FCF with "a gaping wound". No other evidence was found or presented regarding a "face to face" by Complainant with any inmate during the graveyard shift, May 1 - 2, 1998, i.e. there was no evidence that an FCF inmate suffered from a gaping wound during the graveyard shift, May **1** - 2, 1998.

74. In reaching his decision to terminate Complainant's employment the appointing authority considered: A memo submitted by Miriam Crist RN III (Respondent's Exhibit 4, page 2), the Physician's Extender log for May 1 - 2, 1998 (Respondent's Exhibit 4 pg. 3), all the incident reports filed in this matter (Respondent's Exhibit 4); his (the appointing authority's) conversations with ACC correctional staff on duty May 1 - 2, l998, nurse Jordan and Director of Nursing for DOC, Carolyn Schilling *(See* Respondent's Exhibit 19); DOC Nursing Service mission, philosophy and standards of care (Respondent's Exhibit 26); DOC Administrative Regulations and policy (Respondent's Exhibits 20 through 25'h Complainant's position description (Respondent's Exhibit 27); the information presented at the R833 meeting held in this matter; Complainant's written response to the information presented at the R833 meeting and her education and training (Respondent's Exhibit 8); the contradiction in Complainant's version(s) of the incident; any mitigating information presented, including Complainant's past evaluations (Respondent's Exhibits 9 through 15); Complainant's prior corrective action; the seriousness of the outcome for the inmate (death); the increased responsibility that DOC medical personnel carry because the inmates have "diminished autonomy"; that nurse Jordan immediately recognized this life-threatening situation and sent Medina to the hospital and Medina's DOC medical file.

75. In reaching his decision to terminate Complainant's employment the appointing authority did not consider the discipline imposed in similar cases because there were no similar cases. He did not review medical documents/files from local hospitals, admission or discharge notes or documents from local hospitals or the DOC infirmary or any other doctor's orders or notes.

76. Appointing authority was properly delegated to Dr. David Holt. (Respondent's Exhibits 3 and 28.)

## DISCUSSION

In a disciplinary action the burden is upon Respondent to prove by a preponderance of the evidence that the acts, on which the discipline was based, occurred and that just cause warrants the discipline imposed. *Department of Institutions v. Kinchen,* 886 P. 2d 700 (Cob. 1994). The administrative law judge, as the trier of fact, must determine whether the burden of proof has been met. *Metro Moving and Storage Co. v. Gussert,* 914 P. 2d 411 (Cob. App. 1995).

Respondent argues that it met its burden both with regard to 1.) whether or not the act or omission occurred and 2.) whether just cause warrants the discipline imposed.

### 1. Substandard care - whether the act occurred:

Inmate Gerald Medina died on May 2, 1998 after being seen (at approximately 6:30 a.m.) and assessed by ACC day-shift nurse Jordan, then transported to the hospital on "orders" obtained by Jordan. The question here is whether Complainant provided substandard care to Medina during the early morning hours of May 2, 1998, prior to the time he was seen by nurse Jordan. Complainant argues that she followed proper procedure - asked medically significant questions of the correctional officer who called from Arrowhead (ACC) Master Control, that the correctional officer did not timely return a call to Complainant with the answer(s) to her questions and that it would have taken half an hour to get to Medina in order to see him at the Arrowhead (ACC) clinic. Therefore, Complainant argues, considering the last contact she had with Master Control (at approximately 5:20 a.m.), Complainant properly referred the matter to the day-shift nurse, Renae Jordan.

It appears that Complainant did follow procedure. However, her substandard care of Medina lies not in the order in which she handled the report of an inmate in need of medical care. Rather, her care of Medina was substandard because she failed to pursue information, alternatives and see Medina in a timely fashion. Dr. Al-Jalil testified that regardless of procedure, it is the duty of the night nurse, or any DOC medical personnel, to assume that the reported symptoms indicate the worst possible medical scenario and treat the inmate, as if it is a life-and-death situation, even where there is no information regarding medical history. In this case, Complainant appropriately asked questions, the answer(s) to which would have provided medically significant information but she failed to follow-up.

Even if Complainant put the burden on the correctional officer calling from Arrowhead to find out what color the vomitus was, she had sufficient experience, both in the medical field and

with DOC, to know that it could be a life-and-death situation and therefore, she needed to follow-up, i.e. if the officer didn't call her back in 10 minutes, she needed to either keep calling - every 10 minutes, if necessary - until she got the significant information or she should have gone over to Arrowhead to see Medina when she couldn't get the information by phone. Complainant could have called Officer Lynn just as nurse Jordan did or, if she could not leave FCF, she could have requested that Medina be brought to her.

By contrast, while Complainant was not diligently pursuing the care and treatment of the inmate, the correctional officers were doing more, i.e. gathering information, than was required of them within their job duties. Complainant does not persuade that she had duties which took priority over seeing inmate Medina.

In defense of her lack of due diligence, Complainant argues, she had other priorities. She states that she needed to address STAT orders and , on at least one occasion, tried to say that she had a " face to face" with an inmate with a gaping wound. Yet no evidence was presented regarding such inmate and STAT orders by practice, policy and procedure are secondary to seeing an inmate with potentially life-threatening symptoms.

The contradictions in Complainant's comments (e.g. first she indicated that she had been told about a history of bleeding, then she said she had not been told) are sufficient to find that she is not a credible witness. Complainant did not respond with due diligence or due care and therefore she provided substandard care to inmate Medina on May 2, 1998.

**2. Just Cause - whether termination was warranted:**

Respondent argues there are two grounds that support a just-cause termination: 1) Complainant received a prior Corrective Action, also for substandard care by Complainant and 2) the seriousness of this incident.

The imposition of a Disciplinary Action following a Corrective Action for the same activity by Complainant is in line with the practice of progressive discipline. Although the actions of Complainant were not the proximate cause of the inmates death, the fact that Medina died is an indication of the seriousness of the incident and that the situation was a life-threatening situation which required greater attention from Complainant than she gave.

**3. Arbitrary and capricious action**

The discipline imposed, termination of employment, was an alternative that was available to Dr. Holt and it was reasonable under the circumstance set forth in the previous paragraph. Therefore, his actions were not arbitrary, capricious or contrary to rule or law.

## CONCLUSIONS OF LAW

1. Complainant failed "to comply with standards of efficient service or competence", i.e. gave "substandard care" to DOC inmate Gerald Medina (Medina) on May 2, 1998 and under-reported a serious problem, Medina's GI(gastro-intestinal) bleeding.

2. Based on a progressive discipline approach and the seriousness of the incident, just cause warranted termination of Complainant's employment.

3. Respondent's actions in imposing discipline in this matter were not arbitrary, capricious or contrary to rule or law.

4. Respondent's actions were not instituted frivolously, in bad faith, maliciously, or as a means of harassment nor were they otherwise groundless. Therefore Complainant is not entitled to costs including attorney's fees.

*5.* Complainant's actions were not undertaken frivolously, in bad faith, maliciously, or as a means of harassment nor were they otherwise groundless. Therefore Respondent is not entitled to costs including attorney's fees.

## ORDER

Respondent's actions are affirmed.

DONE this 2nd day
April, 1999
Denver, Colorado

Michael S. Gallegos
Administrative Law Judge

CERFICIATE OF MAILING

I, the undersigned, hereby certify that a true and correct copy of the forgoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE was** placed in the United States Mail, postage pre-paid on April _____, 1999, addressed to the following:

Mr. John Keilbach
Altman, Keilbach, Lytle, Parlapiano & Ware
229 Colorado Ave.
Pueblo, Colorado 81002

and in the interoffice mail to:

Ms. Diane Michaud
First Assistant Attorney General
**1525** Sherman St., 5th Floor
Denver, Colorado 80203

**I**

## NOTICE OF APPEAL RIGHTS

*EACH PARTY HAS THE FOLLOWING RIGHTS*

1. *To abide &v the decision of the Administrative Law Judge ("AIJ'3.*

2. *To appeal the decision of the AL] to the State Personnel Board ("Board"). To appeal the decision of the ALI~ a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the AL] is mailed to the parties. Section 24-4-105(15), C.R.S.. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the AL] is mailed to the parties. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline. Vendetti v. University of Southern Colorado. 793 P.2d 657 (Cob. App. 1990); Sections 24-4-105(1 4) and (15), C.R.S.); Rule R-8-58., 4 Code of Cob. Reg. 801. If a written notice of appeal is not received by the Board within thirty calendar days of the mailing date of the decision of the AL.J., then the decision of the AL.J. automatically becomes final. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Cob. App. 1990).*

## ***RECORD ON APPEAL***

*The party appealing the decision of the AL] must pay the cost to prepare the record on appeal. The estimated cost to prepare the record on appeal in this case without a transcript is $50. 00. Payment of the preparation fee may be made either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS.*

*Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 45 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 866-3244.*

## ***BRIEFS ON APPEAL***

*The opening brief of the appellant must be filed with the Board and mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief An original and 7 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double spaced and on 8 1/2 inch by flinch paper only. Rule R-8-64, 4 Code of Cob. Reg. 801.*

## ***ORAL ARGUMENT ON APPEAL***

*A request for oral argument must be filed with the Board on or before the date a party's brief is due. Rule R-8-66, 4 Code of Cob Reg. 801. Requests for oral argument are seldom granted.*

## ***PETITION FOR RECONSIDERATION***

*A petition for reconsideration of the decision of the AL] must be filed within 5 calendar days after receipt of the decision of the AL!. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty calendar day deadline, described above, for filing a notice of appeal of the decision of the ALJ.*